DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96 — 07

2. STATE: KANSAS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 01, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 96 $ 3,750,000
b. FFY 97 $ 11,250,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHED

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHED

10. SUBJECT OF AMENDMENT:
NURSING FACILITY METHODS & STANDARDS FOR ESTABLISHING PAYMENT RATES

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
JANET SCHALANSKY IS THE GOVERNOR'S DESIGNEE

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
JANET SCHALANSKY

14. TITLE:
DEPUTY SECRETARY

15. DATE SUBMITTED:
September 26, 1996

16. RETURN TO:
JANET SCHALANSKY, DEPUTY SECRETARY
KS DEPT OF SOCIAL & REHABILITATION SERV.
DOCKING STATE OFFICE BUILDING
915 HARRISON, 628-S
TOPEKA, KANSAS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/27/96

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/96

20. SIGNATURE OF REGIONAL OFFICIAL:
Thomas W. Lenz

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
Schalansky
Haverkamp
Day
CO

SPA CONTROL
Date Submitted 09/26/96
Date Received 09/27/96

FORM HCFA-179 (07-92)

Instructions on Back

KANSAS MEDICAID STATE PLAN

Form HCFA-179
State Plan MS-96-07
Attachment 4.19 D, Part 1
Nursing Facility

Number of the Plan Section	**Number of the Superseded Plan Section**
Assurance Letter Dated September, 1996	Assurance Letter Dated December 26, 1995 TN-MS 95-19
Exhibit A-9, Pages 1-3	Exhibit A-9, Pages 1-3, TN-MS 92-32
Exhibit C-2, Pages 1-4, 6 and 8	Exhibit C-2, Pages 1-4, 6 and 8, YN-MS 95-15
Exhibit C-3, Pages 1-3	Exhibit C-3, Pages 1-3, TN-MS 95-15
Exhibit C-4	Exhibit C-4, TN-MS 95-15
Exhibit C-5, Pages 1-3	Wxhibit C-5, Pages 1-3, TN-MS 95-15

30-10-21. Reserve days. (a) Payment shall be available for days for which it is necessary to reserve a bed in a nursing facility or nursing facility for mental health when the resident is absent for:

(1) admission to a hospital for acute conditions;

(2) therapeutically indicated home visits with relatives and friends; or

(3) participation in state-approved therapeutic or rehabilitative programs.

(b) In order for payment to be made available, the following conditions shall be met when a bed is reserved in a nursing facility or nursing facility for mental health because of hospitalization for acute conditions.

(1) payment shall be available only for the days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other resident.

(2)(A) The period of hospitalization for an acute condition shall not exceed 10 days per any single hospital stay.

(B) For residents from a nursing facility for mental health, the period of hospitalization shall not exceed 21 days per state mental institution admission or admission to a psychiatric ward in any of the following:

(I) a general hospital;

(ii) a private psychiatric hospital; or

(iii) a veterans administration medical center.

(3) The resident shall intend to return to the same facility after hospitalization.

(4) The hospital shall provide a discharge plan for the resident.

(5) Reimbursement shall not be made to reserve a bed in a swing bed hospital when a nursing facility will be reimbursed for the same day to reserve a bed for the resident's return from the hospital.

(c) The resident's plan of care shall provide for the non-hospital related absence.

(1) payment for non-hospital related reserve days for eligible residents in nursing facilities for mental health shall not exceed 21 days per calendar year, including travel. If additional days are required to obtain or retain employment, participate in a job readiness training program or alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(2) Payment for non-hospital related reserve days for all eligible residents in nursing facilities shall not exceed 12 days per calendar year, including travel. If additional days are required to alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(d) This regulations shall not prohibit any resident from leaving a facility if the resident so desires.

(e) Payments made for unauthorized reserve days shall be reclaimed by the agency.

(f) (1) Before any routine absence by residents, the provider shall notify the local agency office.

(2) In case of emergency admission to a hospital , the provider shall notify the local agency office not later than five working days following admission.

(g) Payment for reserve days shall be approved except when:

(1) the provider has:

(A) more than five vacant beds for nursing facilities having 200 or more beds; or

(2) the absence is longer than 10 hospital days for NF or NF-MH residents or 21 hospital days for NF-MH residents who enter any of the following:

(A) a state mental hospital; or

(B) a psychiatric ward in:

(I) a general hospital;

(ii) a private psychiatric hospital; or

(iii) a veterans administration medical center.

(h) This regulation shall take effect on or after July 1, 1996. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1995, Chapter 153; effective May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; amended, T-30-10-1-90, Oct.1, 1990; amended Jan 30, 1991; amended July 1, 1996.

INFLATION FOR REPORT YEAR ENDS PRIOR TO 7/1/96
EFFECTIVE 07/01/96

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % •
12-94	06-94	1.373	12-96	1.475	7.429%
01-95	07-94	1.384	12-96	1.475	6.575%
02-95	08-94	1.384	12-96	1.475	6.575%
03-95	09-94	1.384	12-96	1.475	6.575%
04-95	10-94	1.394	12-96	1.475	5.811%
05-95	11-94	1.394	12-96	1.475	5.811%
06-95	12-94	1.394	12-96	1.475	5.811%
07-95	01-95	1.408	12-96	1.475	4.759%
08-95	02-95	1.408	12-96	1.475	4.759%
09-95	03-95	1.408	12-96	1.475	4.759%
10-95	04-95	1.414	12-96	1.475	4.314%
11-95	05-95	1.414	12-96	1.475	4.314%
12-95	06-95	1.414	12-96	1.475	4.314%
01-96	07-95	1.422	12-96	1.475	3.727%
02-96	08-95	1.422	12-96	1.475	3.727%
03-96	09-95	1.422	12-96	1.475	3.727%
04-96	10-95	1.432	12-96	1.475	3.003%
05-96	11-95	1.432	12-96	1.475	3.003%
06-96	12-95	1.432	12-96	1.475	3.003%

• = (Midpoint of rate period index / Midpoint of rye index) -1

INFLATION FOR REPORT YEAR ENDS AFTER 7/1/96
EFFECTIVE 07/01/96

RYE	MIDPOINT OF RYE	# OF MONTHS FROM MIDPOINT TO 07-01-97	RED	# OF MONTHS FROM RED TO 07-01-97	INFLATION FACTOR
07-31-96	01-31-96	17	08-01-96	11	2.756%
08-31-96	02-29-96	16	09-01-96	10	2.636%
09-30-96	03-31-96	15	10-01-96	9	2.517%
10-31-96	04-30-96	14	11-01-96	8	2.397%
11-30-96	05-31-96	13	12-01-96	7	2.277%
12-31-96	06-30-96	12	01-01-97	6	2.157%
01-31-97	07-31-96	11	02-01-97	5	2.037%
02-28-97	08-31-96	10	03-01-97	4	1.917%
03-31-97	09-30-96	9	04-01-97	3	1.798%
04-30-97	10-31-96	8	05-01-97	2	1.678%
05-31-97	11-30-96	7	06-01-97	1	1.558%

X = NUMBER OF MONTHS FROM MIDPOINT OF RYE TO 07/01/97
Y = NUMBER OF MONTHS FROM RED TO 07/01/97
FORMULA = 0.2397% • [X-(Y/2)]
ANNUAL RATE OF INFLATION = 2.876%

COST CENTER LIMITATIONS EFFECTIVE 07/01/96

COST CENTER	UPPER LIMIT
Administration	$9.34
Property	$10.52
Room & Board	$18.32
Health Care	$44.39 *

* = Base limit for a facility average case mix index of 1.00

INCENTIVE FACTORS EFFECTIVE 07/01/96

Level	Percentile Range		Per Patient Day Range		Incentive
	Low	High	Low	High	Factor
NF	-0-	30th	$ -0-	11.39	$.50
	31st	55th	11.40	13.47	0.40
	56th	75th	13.48	15.51	0.30
	76th	100th	15.52	above	-0-

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/96

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD
15	5,475	$18,591	$3.40
16	5,840	19,446	3.33
17	6,205	20,301	3.27
18	6,570	21,156	3.22
19	6,935	22,011	3.17
20	7,300	22,866	3.13
21	7,665	23,721	3.09
22	8,030	24,577	3.06
23	8,395	25,432	3.03
24	8,760	26,287	3.00
25	9,125	27,142	2.97
26	9,490	27,997	2.95
27	9,855	28,852	2.93
28	10,220	29,707	2.91
29	10,585	30,563	2.89
30	10,950	31,418	2.87
31	11,315	32,273	2.85
32	11,680	33,128	2.84
33	12,045	33,983	2.82
34	12,410	34,838	2.81
35	12,775	35,693	2.79
36	13,140	36,549	2.78
37	13,505	37,404	2.77
38	13,870	38,259	2.76
39	14,235	39,114	2.75
40	14,600	39,969	2.74
41	14,965	40,824	2.73
42	15,330	41,679	2.72
43	15,695	42,535	2.71
44	16,060	43,390	2.70
45	16,425	44,245	2.69
46	16,790	45,100	2.69
47	17,155	45,955	2.68
48	17,520	46,810	2.67
49	17,885	47,665	2.67
50	18,250	48,521	2.66

F/Y	Amount	Cost of Living State Emp.
76	10,000	---
77	10280	2.800%
78	10537	2.500%
79	11301	7.250%
80	11781	4.250%
81	12617	7.100%
82	13248	5.000%
83	14109	6.500%
84	14426	2.250%
85	15147	5.000%
86	15933	5.190%
87	16411	3.000%
88	16575	1.000%
89	17238	4.000%
90	17755	3.000%
91	18021	1.500%
92	18021	0.000%
93	18111	0.500%
94	18202	0.500%
95	18407	1.125%
96	18591	1.000%
97	18591	0.000%

90th Percentile PPD Administrator & Co-Administrator Salary.

CASE MIX INDEX TABLE EFFECTIVE 07/01/96

RUG-III GROUP	CODE	CMI
SPECIAL REHABILITATION		
REHAB VERY HI 14-18	RVC	4.26
REHAB VERY HI 8-13	RVB	3.49
REHAB VERY HI 4-7	RVA	3.33
REHAB HI 15-18	RHD	3.51
REHAB HI 12-14	RHC	2.87
REHAB HI 8-11	RHB	2.84
REHAB HI 4-7	RHA	2.62
REHAB MED 16-18	RMC	2.59
REHAB MED 8-15	RMB	2.13
REHAB MED 4-7	RMA	2.03
REHAB LO 12-18	RLB	1.61
REHAB LO 4-11	RLA	1.46
EXTENSIVE SERVICES		
EXTENSIVE 3	SE3	4.23
EXTENSIVE 2	SE2	2.47
EXTENSIVE 1	SE1	1.67
SPECIAL CARE		
SPECIAL CARE 17-18	SSC	1.50
SPECIAL CARE 14-16	SSB	1.34
SPECIAL CARE 7-13	SSA	1.27
CLINICALLY COMPLEX		
COMPLEX 17-18 D	CD2	1.31
COMPLEX 17-18	CD1	1.26
COMPLEX 11-16 D	CC2	1.18
COMPLEX 11-16	CC1	1.10
COMPLEX 6-10 D	CB2	1.12
COMPLEX 6-10	CB1	1.00
COMPLEX 4-5 D	CA2	0.98
COMPLEX 4-5	CA1	0.81

RUG-III GROUP	CODE	CMI
IMPAIRED COGNITION		
IMPAIRED 6-10 N	IB2	0.97
IMPAIRED 6-10	IB1	0.88
IMPAIRED 4-5 N	IA2	0.78
IMPAIRED 4-5	IA1	0.67
BEHAVIOR PROBLEMS		
BEHAVIOR 6-10 N	BB2	0.99
BEHAVIOR 6-10	BB1	0.87
BEHAVIOR 4-5 N	BA2	0.69
BEHAVIOR 4-5	BA1	0.61
REDUCED PHYSICAL FUNCTIONS		
PHYSICAL 16-18 N	PE2	1.07
PHYSICAL 16-18	PE1	1.02
PHYSICAL 11-15N	PD2	1.01
PHYSICAL 11-15	PD1	0.96
PHYSICAL 9-10 N	PC2	0.90
PHYSICAL 9-10	PC1	0.90
PHYSICAL 6-8 N	PB2	0.80
PHYSICAL 6-8	PB1	0.71
PHYSICAL 4-5 N	PA2	0.71
PHYSICAL 4-5	PA1	0.58

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/96

	BEFORE INFLATION					***AFTER INFLATION***				
	ADMIN	PLT OP	RM&BRD	HLTCR	TOTAL	ADMIN	PLT OP	RM&BRD	HLTCR	TOTAL
MEDIAN	7.84	4.94	13.51	34.04	59.99	8.12	5.15	14.09	35.51	62.48
MEAN	8.89	5.48	14.50	35.52	64.40	9.18	5.70	15.12	37.05	67.06
WTMN	8.28	5.28	14.14	35.07	62.76	8.55	5.48	14.75	36.58	65.36
# OF PROV	387									

COMPILATION OF ADMINISTRATOR, CO-ADMINISTRATOR AND OWNER EXPENSE - O/A LIMIT

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & CO-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	162,754	39.55	43,552	1.27	162,754	39.55	242,285	6.56
99th	66,326	4.30	43,552	1.27	85,908	4.30	207,801	5.54
95th	57,235	2.87	36,000	1.16	60,238	2.96	114,126	4.07
90th	49,225	2.61	34,729	1.15	52,437	2.66	73,901	3.22
85th	45,696	2.47	31,803	1.08	47,000	2.51	57,319	2.61
80th	44,753	2.32	28,026	1.04	45,219	2.37	46,397	2.07
75th	43,181	2.23	27,553	0.95	44,319	2.25	38,010	1.59
70th	41,592	2.12	27,290	0.92	42,354	2.14	25,938	1.10
65th	40,115	2.04	26,201	0.91	40,691	2.06	19,992	0.92
60th	39,156	1.93	25,161	0.82	39,600	1.98	19,615	0.83
55th	38,049	1.87	23,750	0.82	38,400	1.91	14,933	0.73
50th	37,042	1.75	18,269	0.72	37,285	1.81	12,858	0.63
40th	34,986	1.61	16,178	0.64	35,043	1.65	9,141	0.48
30th	32,443	1.48	14,658	0.37	32,521	1.50	7,450	0.36
20th	29,826	1.30	4,072	0.20	29,826	1.31	4,800	0.24
10th	22,200	1.12	1,213	0.05	22,200	1.14	3,020	0.12
1st	9,197	0.72	650	0.04	9,197	0.74	1,447	0.08
LOW	5,501	0.55	650	0.04	5,501	0.55	-13,787	-3.28
MEAN	37,309	1.95	19,386	0.67	38,175	1.98	29,140	1.13
WTMN	40,098	1.71	21,805	0.67	41,352	1.75	35,139	1.18
# of Prov	360		22		363		147	

COMPILATION OF LINE ITEM INPUTS TO INCENTIVE FACTOR

	INCENTIVE AMOUNT
HIGH	397.30
99th	64.39
95th	20.69
90th	18.52
85th	17.23
80th	16.08
75th	15.51
70th	14.97
65th	14.40
60th	13.91
55th	13.47
50th	13.05
40th	12.24
30th	11.39
20th	10.53
10th	9.52
1st	7.31
LOW	6.18
MEAN	15.37
WTMN	13.90
# of Prov	384

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

June 20, 1996

FIELD(1)
FIELD(2)
FIELD(3)
FIELD(4)

Dear Administrator: FIELD(5)

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for FIELD(6) (computer print-out) to our fiscal agent, EDS-Federal. The rate is effective FIELD(7). The payment schedule and rate reflect the cost center limitations, including the case mix adjustment in the Health Care cost center, inflation factors, owner/related party/administrator compensation per diem limitations and incentive ranges.

SRS determined this rate by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data shown on the enclosed payment schedule. Desk review adjustments to the cost report are shown on the enclosed Provider Adjustment Sheet, except transfers from one line to another, which are shown in the "Reason for SRS Adjustments" column of the schedule. (All related transfers in this column have the same key number.) **IF YOU HAVE QUESTIONS ABOUT ANY DESK REVIEW ADJUSTMENT, CALL THE ADULT CARE HOME PROGRAM'S AUDIT MANAGER IN SRS AUDIT SERVICES AT (913) 296-3836.**

THE FACILITY'S RATE FOR NON MEDICAID/MEDIKAN RESIDENTS MUST EQUAL OR EXCEED THE MEDICAID/MEDIKAN RATE FOR COMPARABLE CARE AND SERVICES. If the private pay rate indicated on the agency register is lower, then the Medicaid/Medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry. The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency. **SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).**

If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the **SRS Administrative Hearings Section, 2nd Floor, 610 West Tenth, Topeka, Kansas 66612** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to me or call at (913) 296-0703.

Sincerely,

Bill McDaniel, Administrator
Nursing Facility Reimbursement
Adult and Medical Services Commission

0614962403210011

12345678901234567890 1234

STATE OF KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
DIVISION OF MEDICAL SERVICES - MEDICAID ADULT CARE HOME COST ANALYSIS

CASE MIX SCHEDULE
1ST QRT 1997
PAGE 1

* * * * * * PROVIDER INFORMATION * * * * * *

PROVIDER NO....

FACILITY NAME.....
ADDRESS.....
CITY/STATE/ZIP....
ADMINISTRATOR.....

REPORT YEAR END... 12/31/95
FISCAL YEAR END... 12/31/95

INFLATION FACTOR.. 4.314

CMI..... 1.07

BEDS AVAILABLE	PRIOR	CURRENT	%CHG
NURSING FACILITY.....	58	58	0.0
NF-MENTAL HEALTH.....	0	0	0.0
OTHER.....	0	0	0.0
TOTAL.....	58	58	0.0
BED DAYS AVAILABLE...	17,525	21,170	20.8
INPATIENT DAYS.....	15,392	16,005	4.0
OCCUPANCY RATE.....	87.8	75.6	-13.9
MEDICAID DAYS.....	7,913	7,823	-1.1
CAL DAYS IF APPL.....	0	0	
RES DAYS USED IN DIV.	15,392	17,995	

* * * * * * RECAP OF RESIDENT RELATED EXPENSES AND RATE CALCULATION * * * * * *

	ADMIN	PLANT OPERATING	ROOM & BOARD	HEALTH CARE	TOTAL
RES RELATED EXP.....	136,145	115,159	321,351	690,206	1,262,861
COST PER RESIDENT DAY....	7.57	6.40	17.86	38.36	70.19
INFLATION.....	0.26	0.28	0.77	1.65	2.96
PPD COST BEFORE LIMITS...	7.83	6.68	18.63	40.01	73.15
PPD COST LIMITS.....NF	9.34	4.86	18.32	47.50	80.02
ALLOWED COST.....	7.83	4.86	18.32	40.01	71.02

		NF
ALLOWED COST.....		71.02
INCENTIVE FACTOR.....		0.30
REAL AND PERSONAL PROPERTY FEE.....		5.66
24-HR NURSING ADJUSTMENT.....		0.00
PER RESIDENT DAY RATE EFFECTIVE.....	07/01/96	76.98
PRIVATE PAY RATE.....	09/01/95	78.50

EXPENSE STATEMENT

DESCRIPTION	LINE NO.	CURRENT YEAR REPORTED EXPENSE	PROVIDER ADJUSTMT	SRS ADJUSTMT	CURRENT YEAR RESIDENT EXPENSE	CURRENT YEAR PER DAY	PRIOR YEAR RESIDENT EXPENSE	PRIOR YEAR PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
ADMINISTRATION											
SALARY-ADMIN	101	27,146	0	0	27,146	1.51	39,289	2.55	-40.78	101	
SALARY-CO ADM	102	0	0	0	0	0.00	0	0.00	0.00	102	
OTHER ADM SAL	103	48,512	0	0	48,512	2.70	22,200	1.44	87.50	103	
EMP BENEFITS	104	13,716	0	0	13,716	0.76	10,674	0.69	10.14	104	
OFC SUP & PRINT	105	6,776	0	0	6,776	0.38	9,153	0.59	-35.59	105	
MGT CONSULTING	106	485	0	0	485	0.03	575	0.00	100.00	106	
OWN/REL PTY CMP	107	0	0	0	0	0.00	0	0.00	0.00	107	
CENTRAL OFC	108	0	0	0	0	0.00	0	0.00	0.00	108	
PHONE & COMMUNI	109	2,916	0	0	2,916	0.16	2,012	0.13	23.08	109	
TRAVEL	110	1,125	0	0	1,125	0.06	2,264	0.15	-60.00	110	
ADVERTISING	111	1,518	0	0	1,518	0.08	1,794	0.12	-33.33	111	
LICENSES & DUES	112	2,065	0	0	2,065	0.11	2,834	0.18	-38.89	112	
LEGAL/ACCTG DP	113	7,575	0	0	7,575	0.42	7,967	0.52	-19.23	113	
INS EXCEPT LIFE	114	21,103	0	0	21,103	1.17	17,288	1.12	0.00	114	
INT EXCEPT R/E	115	0	0	0	0	0.00	0	0.00	0.00	115	
LEGAL	116	0	0	0	0	0.00	0	0.00	0.00	116	
OTHER	117	854	0	0	854	0.05	421	0.03	66.67	117	
OTHER	118	2,354	0	0	2,354	0.13	0	0.00	100.00	118	
O/A LIMIT	119	0	0	0	0	0.00	-501	-0.03	0.00	119	
TOTAL ADMIN	120	136,145	0	0	136,145	7.57	115,970	7.53	0.53	120	
PLANT OPERATING											
R/E & PP TAXES	121	0	0	0	0	0.00	0	0.00	0.00	121	
SALARIES	126	38,861	0	0	38,861	2.16	33,839	2.20	-1.82	126	
EMP BENEFITS	127	5,524	0	0	5,524	0.31	5,871	0.38	-18.42	127	
OWN/REL PTY CMP	128	0	0	0	0	0.00	0	0.00	0.00	128	
UTILITIES	129	48,363	0	0	48,363	2.69	38,579	2.51	7.17	129	
MAINT & REPAIR	130	19,311	0	0	19,311	1.07	17,512	1.14	-6.14	130	
SUPPLIES	131	865	0	0	865	0.05	1,572	0.10	-50.00	131	
SMALL EQUIPMENT	137	1,037	0	0	1,037	0.06	3,618	0.24	-75.00	137	
OTHER	138	1,198	0	0	1,198	0.07	256	0.02	250.00	138	
TOTAL PLANT OP	139	115,159	0	0	115,159	6.40	101,247	6.58	-2.74	139	
ROOM & BOARD											
EMP BENEFITS	141	29,083	0	0	29,083	1.62	31,864	2.07	-21.74	141	
DIETARY-SAL	142	162,745	0	0	162,745	9.04	147,390	9.58	-5.64	142	
OWN/REL PTY CMP	143	0	0	0	0	0.00	0	0.00	0.00	143	
CONSULTANT	144	0	0	0	0	0.00	0	0.00	0.00	144	
FOOD	145	65,545	0	0	65,545	3.64	60,516	3.93	-7.38	145	
SUPPLIES	146	9,644	0	0	9,644	0.54	9,558	0.62	-12.90	146	
OTHER	148	34	0	0	34	0.00	513	0.03	0.00	148	
LAUNDRY-LINEN-SAL	149	33,985	0	0	33,985	1.89	30,135	1.96	-3.57	149	
LINEN - BEDDING	150	7,028	0	0	7,028	0.39	7,253	0.47	-17.02	150	
SUPPLIES	151	3,925	0	0	3,925	0.22	3,641	0.24	-8.33	151	
OTHER	153	0	0	0	0	0.00	0	0.00	0.00	153	
HOUSEKEEPING-SAL	154	7,867	0	0	7,867	0.44	6,028	0.39	12.82	154	
SUPPLIES	155	1,495	0	0	1,495	0.08	1,013	0.07	14.29	155	
OTHER	158	0	0	0	0	0.00	0	0.00	0.00	158	
TOTAL RM & BOARD	159	321,351	0	0	321,351	17.86	297,911	19.35	-7.70	159	

* * * * * * EXPENSE STATEMENT * * * * * *

DESCRIPTION	LINE NO.	REPORTED EXPENSE	PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	RESIDENT EXPENSE	PER DAY	PRIOR YEAR RESIDENT EXPENSE	PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
EALTH CARE											
NURSING-RN	161	54,184	0	0	54,184	3.01	68,487	4.45	-32.36	161	
LPN/LMHT	162a	117,134	0	0	117,134	6.51	76,109	4.94	31.78	162a	
LPN/LMHT	162b	0	0	0	0	0.00	0	0.00	0.00	162b	
OTHER NURSING	163a	342,033	0	0	342,033	19.01	336,148	21.84	-12.96	163a	
OTHER NURSING	163b	0	0	0	0	0.00	0	0.00	0.00	163b	
OTHER NURSING	163c	0	0	0	0	0.00	0	0.00	0.00	163c	
EMP BENEFITS	164	81,159	0	0	81,159	4.51	94,097	6.11	-26.19	164	
OWN/REL PTY CMP	165	0	0	0	0	0.00	0	0.00	0.00	165	
CONSULTANTS	166	0	0	0	0	0.00	0	0.00	0.00	166	
PURCH SERVICES	167	0	0	0	0	0.00	0	0.00	0.00	167	
SUPPLIES	168	9,979	0	0	9,979	0.55	9,785	0.64	-14.06	168	
OTHER	170	2,787	0	0	2,787	0.15	2,249	0.15	0.00	170	
THPY/OTHER SAL	171a	22,015	0	0	22,015	1.22	15,038	0.98	24.49	171a	
THPY/OTHER SAL	171b	0	0	0	0	0.00	0	0.00	0.00	171b	
THPY/OTHER SAL	171c	0	0	0	0	0.00	0	0.00	0.00	171c	
THPY/OTHER SAL	171d	0	0	0	0	0.00	0	0.00	0.00	171d	
THPY/OTHER SAL	171e	0	0	0	0	0.00	0	0.00	0.00	171e	
THPY/OTHER SAL	171f	0	0	0	0	0.00	0	0.00	0.00	171f	
OWN/REL PTY CMP	172	0	0	0	0	0.00	0	0.00	0.00	172	
PAT ACT/SOC WKR	173a	17,148	0	0	17,148	0.95	15,941	1.04	-8.65	173a	
PAT ACT/SOC WKR	173b	18,453	0	0	18,453	1.03	11,464	0.74	39.19	173b	
PAT ACT/SOC WKR	173c	20,839	0	0	20,839	1.16	18,852	1.22	-4.92	173c	
PAT ACT/SOC WKR	173d	0	0	0	0	0.00	0	0.00	0.00	173d	
PAT ACT SUPPLS	174	1,865	0	0	1,865	0.10	1,644	0.11	-9.09	174	
OCCUP THERAPY	175	0	0	0	0	0.00	0	0.00	0.00	175	
MED RECORDS-CON	176	425	0	0	425	0.02	1,643	0.11	-81.82	176	
PHARM-CONSULTANTS	177	0	0	0	0	0.00	0	0.00	0.00	177	
SPEECH THERAPY	178	0	0	0	0	0.00	0	0.00	0.00	178	
PHYSICAL THERAPY	179	0	0	0	0	0.00	0	0.00	0.00	179	
CONSULTANT	180	157	0	0	157	0.01	1,331	0.09	-88.89	180	
NURSING TRNG	181a	1,946	0	0	1,946	0.11	2,807	0.18	-38.89	181a	
NURSING TRNG	181b	82	0	0	82	0.00	0	0.00	0.00	181b	
RESIDENT TRANSP	182	0	0	0	0	0.00	0	0.00	0.00	182	
OTHER	183	0	0	0	0	0.00	0	0.00	0.00	183	
OTHER	188	0	0	0	0	0.00	0	0.00	0.00	188	
TOTAL HLTH CARE	189	690,206	0	0	690,206	38.36	655,595	42.59	-9.93	189	
TOTAL ALLOWABLE	190	1,262,861	0	0	1,262,861	70.19	1,170,723	76.05	-7.71	190	
NERSHIP											
NT-R/E MORTG	191	0	0	0	0	0.00	0	0.00	0.00	191	
ENT/LEASE	192	8,715	0	0	8,715	0.48	7,204	0.47	2.13	192	
EASEHOLD IMPRV	193	0	0	0	0	0.00	0	0.00	0.00	193	
EPRECIATION	194	145,250	0	0	145,250	8.07	79,265	5.15	56.70	194	
TOTAL OWNERS	195	153,965	0	0	153,965	8.56	86,469	5.62	27.10		

AL AND PERSONAL PROPERTY FEE COMPONENT

FF DATE	RES DAYS	MTG INT	RENT/LEASE	AMORT	DEPR	TOTAL	PPD	PROP ALLOW	VALUE FACTOR	PROP FEE
9/01/94	17,994	3,343	0	0	86,973	90,316	5.02	5.66	0.00	5.66

PL

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

Mr. Richard P. Brummel
Associate Regional Administrator for the
Division of Medicaid
Room 235, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs-Mental Health (MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(b) Findings

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

42 CFR 447.253(b)(1)(i) Payment Rates

The State of Kansas continues to pay NFs and NFs-MH for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(iii) Payment Rates

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-96-07

ARP JUN 06 2001

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour basis;

(C) The State of Kansas established procedures under which the data and methodology used in establishing payment rates are made available to the public.

42 CFR 447.253(b)(2) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment is reasonably expected to pay no more in the aggregate for NF and NF-MH services than the amount the agency reasonably estimates would be paid under the Medicare principles of reimbursement. There are no state operated NFs or NFs-MH so 447.272(b) does not apply.

42 CFR 447.253(d) Changes in Ownership of NFs and ICFs-MR

The State of Kansas assures that its NFs and NFs-MH payment methodology is not reasonably expected to result in an increase in aggregate payments based solely as the result of a change in ownership in excess of the increase that would result from application of 447.253(d)(1) and (2).

42 CFR 447.253(e) Provider Appeals

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides a fair hearing, appeal or exception procedure that allows for an administrative review and appeal by the provider as to their payment rates.

42 CFR 447.253(f) Uniform Cost Reporting

Nursing facility and NF-MH providers are required to file annual uniform cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part I, Methods and Standards for Establishing Payment Rates.

42 CFR 447.253(g) Audit Requirements

The State of Kansas performs a review on all cost reports within six months of receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

42 CFR 447.253(h) Public Notice

In accordance with 42 CFR 447.205, public notice is given for the significant changes proposed to the methods and standards for setting NF and NF-MH payment rates.

Refers to MS-96-07

42 CFR 447.253(i) Rates Paid

The State of Kansas assures that payment rates are determined in accordance with methods and standards specified in an approved State Plan.

42 CFR 447.255 Related Information

Estimated Average NF/NF-MH Rate:	7/1/96	$67.11
Estimated Average NF/NF-MH Rate:	7/1/95	$63.68
Per Diem Increase		3.43
Average Percent Increase		5.39%

Both the short-term and long-term effect of these changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.

   There are approximately 399 licensed NFs or NFs-MH in the State of Kansas with at least one in every county. Of these, 394 or 99% are certified to participate in the Medicaid Program. There are 12 licensed NFs-MH in the State of Kansas and all of them participate in the Medicaid program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and

3. Maintain the extent of provider participation.

   The extent of provider participation should not be affected by this change. Ninety-eight percent of the available providers are already participating in the program.

Any questions regarding this Plan submission should be directed to Marti Malcolm or Bill McDaniel at (913) 296-3981.

Sincerely,

Janet Schalansky
Deputy Secretary

JS:AEK:bpl

Refers to MS-96-07